AMENDED IN SENATE APRIL 10, 2003

# SENATE BILL No. 857

**Introduced by Senator Speier**

February 21, 2003

~~An act to add Section 100186 to the Health and Safety Code, relating to health care.~~ *An act to add Sections 14087.302 and 14107.12 to the Welfare and Institutions Code, relating to Medi-Cal.*

LEGISLATIVE COUNSEL'S DIGEST

SB 857, as amended, Speier. ~~State Department of Health Services~~ *Medi-Cal*: fraud.

*Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.*

*Existing law imposes various functions and duties on the Controller with respect to the fiscal operation of the state including the authority to audit the disbursement of any state money for certain purposes.*

*This bill would require the Controller to conduct a fraud audit of the Medi-Cal program that would include specified information to determine the level of provider fraud in the Medi-Cal program, and to report the results of the audit to specified legislative committees on or before August 1, 2004. It would also require the department to secure funding for the fraud audit, and to cooperate with the Controller to ensure an accurate and comprehensive audit.*

*Existing law authorizes the Director of Health Services to contract with any qualified individual, organization, or entity to provide services to, arrange for or case manage, the care of Medi-Cal beneficiaries.*

*This bill would require the department to include in its Medi-Cal managed care contracts a requirement that each health plan fund a comprehensive special investigative unit to investigate provider and beneficiary fraud within that health plan's Medi-Cal beneficiary and provider network. It would also require that these contracts include requirements that the health plan provide specified information to the department regarding the special investigative unit and that the health plan determine the cost benefit ratio of its special investigative unit.*

~~Existing law creates the State Department of Health Services, with various powers and duties relative to public health.~~

~~This bill would require the department to seek to reduce fraud in the programs it administers by increasing the use of information technology to systematically detect fraud.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

~~SECTION 1. Section 100186 is added to the Health and Safety Code, to read:~~

~~100186. The department shall seek to reduce fraud in the programs it administers by increasing the use of information technology to systematically detect fraud.~~

*SECTION 1. The Legislature finds and declares all of the following:*

*(a) In 2002–03, the total budget for the Medi-Cal program has grown to $29.2 billion, of which approximately one-half of the budget is supported by the General Fund.*

*(b) In 2002–03, the State Department of Health Services is budgeted to spend $22.8 million on fraud control activities, or approximately 0.08 percent of the total Medi-Cal budget.*

*(c) Experts estimate the level of fraud in the Medi-Cal program to be at least 10 percent, or $2.9 billion.*

*(d) California has never done a fraud audit of the Medi-Cal program, and therefore cannot estimate the level of fraud in the program.*

*(e) Knowing the level of fraud in the Medi-Cal program is important as it provides a benchmark regarding the amount of funds the state should spend in trying to detect and prevent it.*

*(f) In 2001, the federal Centers for Medicare and Medicaid Services (CMS) published a State Medicaid Director letter inviting states to participate in developing a payment accuracy measurement methodology for medicaid. CMS subsequently funded nine states to conduct these studies, but California did not apply to be part of this pilot.*

*SEC. 2. Section 14087.302 is added to the Welfare and Institutions Code, to read:*

*14087.302. The department shall include in its Medi-Cal managed care contracts, a requirement that each health plan fund a comprehensive special investigative unit to investigate provider and beneficiary fraud within that health plan's Medi-Cal beneficiary and provider network. These contracts shall also include requirements that the health plan provide to the department information on the level of staffing and activities of the special investigative unit, and that the health plan determine the cost benefit ratio of its special investigative unit.*

*SEC. 3. Section 14107.12 is added to the Welfare and Institutions Code, to read:*

*14107.12. (a) (1) The Controller shall conduct a fraud audit of the Medi-Cal program to determine the level of provider fraud in the Medi-Cal program. The provider fraud audit shall include at least four types of inquiry, including, but not limited to, claims examination, contextual data analysis, patient interviews, and unannounced visits.*

*(2) Claims examination shall focus on the issues of medical orthodoxy, policy coverage, and price, as well as a review of unusual or suspicious claims.*

*(3) "Contextual data analysis" means examining the claim within its broader data context that would include, but would not be limited to; an examination of the provider's aggregate billing behaviors and billing profile, the patient's aggregate treatment patterns and profile, duplicate, similar, or related claims, referral patterns, coincidences, cluster, or structures in surrounding billings, business relationships between providers and referring physicians; and ownership arrangements and the potential for kickbacks.*

*(4) Patient interviews shall verify the relationship with the provider, the diagnosis, and the treatment provided and, preferably, should be done in person.*

*(5) Unannounced visits shall be required if the other types of inquiry indicate grounds for suspicion of fraud.*

*(b) The department shall secure funding for the fraud audit, including matching federal funds, in its role as the single state medicaid agency. The department shall cooperate with the Controller to ensure an accurate and comprehensive audit.*

*(c) On or before August 1, 2004, the Controller shall report the results of the fraud audit to the Senate Select Committee on Government Oversight and the Senate Health Committee.*

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